

<i>SERFF Tracking Number:</i>	<i>MDIC-125892039</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Medico Insurance Company</i>	<i>State Tracking Number:</i>	<i>40790</i>
<i>Company Tracking Number:</i>	<i>KHRE487DV</i>		
<i>TOI:</i>	<i>H10I Individual Health - Dental</i>	<i>Sub-TOI:</i>	<i>H10I.000 Health - Dental</i>
<i>Product Name:</i>	<i>RE487DV</i>		
<i>Project Name/Number:</i>	<i>/</i>		

Filing at a Glance

Company: Medico Insurance Company
Product Name: RE487DV
TOI: H10I Individual Health - Dental
Sub-TOI: H10I.000 Health - Dental
Filing Type: Form

SERFF Tr Num: MDIC-125892039	State: ArkansasLH
SERFF Status: Closed	State Tr Num: 40790
Co Tr Num: KHRE487DV	State Status: Approved-Closed
Co Status:	Reviewer(s): Rosalind Minor
Author: Karl Hug	Disposition Date: 11/10/2008
Date Submitted: 11/07/2008	Disposition Status: Approved-Closed
	Implementation Date:

Implementation Date Requested: On Approval
State Filing Description:

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 11/10/2008
State Status Changed: 11/10/2008
Corresponding Filing Tracking Number:
Filing Description:

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:

Deemer Date:

Filing of an elimination rider to be used with our previously approved Dental, Vision and Hearing policy, please see my attached cover letter for more information about this filing, thanks.

Company and Contact

Filing Contact Information

Karl Hug, Compliance Analyst

khug@gomedico.com

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1515 S. 75th Street	(800) 695-5976 [Phone]
Omaha, NE 68124	(402) 391-4858[FAX]

Filing Company Information

Medico Insurance Company	CoCode: 31119	State of Domicile: Nebraska
1515 S. 75th Street	Group Code: 364	Company Type: Life and Health
Omaha, NE 68124	Group Name: Medico	State ID Number:
(800) 695-5976 ext. [Phone]	FEIN Number: 47-0122200	

SERFF Tracking Number:	MDIC-125892039	State:	Arkansas
Filing Company:	Medico Insurance Company	State Tracking Number:	40790
Company Tracking Number:	KHRE487DV		
TOI:	H101 Individual Health - Dental	Sub-TOI:	H101.000 Health - Dental
Product Name:	RE487DV		
Project Name/Number:	/		

Filing Fees

Fee Required?	Yes
Fee Amount:	\$20.00
Retaliatory?	No
Fee Explanation:	one form, filing fee is \$20.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medico Insurance Company	\$20.00	11/07/2008	23778214

SERFF Tracking Number:	MDIC-125892039	State:	Arkansas
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TOI:	H101 Individual Health - Dental	Sub-TOI:	H101.000 Health - Dental
Product Name:	RE487DV		
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/10/2008	11/10/2008

SERFF Tracking Number: MDIC-125892039

State: Arkansas

Filing Company: Medico Insurance Company

State Tracking Number: 40790

Company Tracking Number: KHRE487DV

TOI: H101 Individual Health - Dental

Sub-TOI: H101.000 Health - Dental

Product Name: RE487DV

Project Name/Number: /

Disposition

Disposition Date: 11/10/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>MDIC-125892039</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Medico Insurance Company</i>	<i>State Tracking Number:</i>	<i>40790</i>
<i>Company Tracking Number:</i>	<i>KHRE487DV</i>		
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	application	Approved-Closed	Yes
Supporting Document	flesch score Cert.	Approved-Closed	Yes
Supporting Document	cover letter	Approved-Closed	Yes
Form	elimination rider for A18, hearing aids	Approved-Closed	Yes

SERFF Tracking Number:	MDIC-125892039	State:	Arkansas
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TOI:	H101 Individual Health - Dental	Sub-TOI:	H101.000 Health - Dental
Product Name:	RE487DV		
Project Name/Number:	/		

Form Schedule

Lead Form Number: RE487DV

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	RE487DV	Policy/Cont elimination rider for ract/Fratern A18, hearing aids al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		63	RE487DV-10302008.pdf

-ENDORSEMENT-

MEDICO™ INSURANCE COMPANY
1515 SOUTH 75TH STREET
OMAHA, NE 68124

POLICY NUMBER - XXXXXXXX

RIDER PAGE 1 OF 1

ELIMINATION RIDER

This rider is part of the policy to which it is attached. It is subject to all the policy provisions.

Based on your past health history, your policy will not pay benefits for the purchase of hearing aids unless the expenses are incurred after the first Policy Year.

Accepted by: _____
(Signature of Insured)

RE487DV

10302008

ANY ENDORSEMENT IS A PART OF YOUR POLICY. THE NUMBER IS SHOWN ABOVE.



President

SERFF Tracking Number: MDIC-125892039

State: Arkansas

Filing Company: Medico Insurance Company

State Tracking Number: 40790

Company Tracking Number: KHRE487DV

TOI: H101 Individual Health - Dental

Sub-TOI: H101.000 Health - Dental

Product Name: RE487DV

Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	MDIC-125892039	State:	Arkansas
Filing Company:	Medico Insurance Company	State Tracking Number:	40790
Company Tracking Number:	KHRE487DV		
TOI:	H101 Individual Health - Dental	Sub-TOI:	H101.000 Health - Dental
Product Name:	RE487DV		
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Supporting Document Schedules

Satisfied -Name:	Certification/Notice	Review Status:	Approved-Closed	11/10/2008
Comments:				
Attachment:				
	AR-Certi 11072008.pdf			

Bypassed -Name:	Application	Review Status:	Approved-Closed	11/10/2008
Bypass Reason:	The previously approved application for this product is attached below, for reference purposes, thanks.			
Comments:				

Bypassed -Name:	Health - Actuarial Justification	Review Status:	Approved-Closed	11/10/2008
Bypass Reason:	N/A to this filing.			
Comments:				

Bypassed -Name:	Outline of Coverage	Review Status:	Approved-Closed	11/10/2008
Bypass Reason:	N/A to this filing.			
Comments:				

Satisfied -Name:	application	Review Status:	Approved-Closed	11/10/2008
Comments:				
Attachment:				
	MIHAA18(AR)-04072008.pdf			

Satisfied -Name:	flesch score Cert.	Review Status:	Approved-Closed	11/10/2008
Comments:				
Attachment:				

SERFF Tracking Number: *MDIC-125892039*

State: *Arkansas*

Filing Company: *Medico Insurance Company*

State Tracking Number: *40790*

Company Tracking Number: *KHRE487DV*

TOI: *H101 Individual Health - Dental*

Sub-TOI: *H101.000 Health - Dental*

Product Name: *RE487DV*

Project Name/Number: */*

Flesch Certif 11072008.pdf

SERFF Tracking Number: MDIC-125892039

State: Arkansas

Filing Company: Medico Insurance Company

State Tracking Number: 40790

Company Tracking Number: KHRE487DV

TOI: H101 Individual Health - Dental

Sub-TOI: H101.000 Health - Dental

Product Name: RE487DV

Project Name/Number: /

Review Status:

Satisfied -Name: cover letter

Approved-Closed

11/10/2008

Comments:

Attachment:


Elim Rider AR 11072008.pdf

ARKANSAS CERTIFICATION

Medico™ Insurance Company hereby

Insurer

certifies that this filing complies with the requirements of Arkansas Insurance Rule and Regulation 19 as well as all other requirements of the Arkansas Insurance Department.


Signature

Desiree Buckley, VP & Director of Compliance
Officer's name and title

Date 11/07/2008

Application for Dental, Vision and Hearing Insurance

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Part A: General Information – Please Print
Applicant Information

Name _____	Date of Birth (Mo./Day/Yr.) _____	Age _____	Sex _____
Address _____			
Street Address _____	City _____	State _____	Zip _____
Social Security # _____			
Phone # _____	E-mail Address _____		

Co-Applicant Information

Name _____	Date of Birth (Mo./Day/Yr.) _____	Age _____	Sex _____
Social Security # _____			
E-mail Address _____			

Part B: Medical Information

	Applicant Yes No	Co-Applicant Yes No
1. (a) Do you currently wear dentures?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Have you been advised to have any dental work which has not been completed? If "Yes," provide details: Applicant: _____ Co-Applicant: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
2. (a) Do you currently wear eyeglasses or contact lenses?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Have you received advice or treatment within the past nine months for correction of a vision problem? If "Yes," provide details: Applicant: _____ Co-Applicant: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
3. (a) Do you currently wear a hearing aid?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Have you been treated for hearing loss within the past nine months?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(c) Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Part C: Applicant Information

1. (a) Do you have any dental, vision or hearing insurance currently in force?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(b) Is the insurance applied for intended to replace any existing insurance with this or any other company? If "Yes," provide type of contract or policy number, and name of company: Applicant: _____ Co-Applicant: _____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>
(c) If replacement is involved, have you received a replacement form (in states where required by law)?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

Part D: Benefit Option
Applicant: Check the Benefit you prefer:

 Policy Year Maximum: ☐ \$1,000 ☐ \$1,500

Co-Applicant: Check the Benefit you prefer:

 Policy Year Maximum: ☐ \$1,000 ☐ \$1,500

Part E: Payment Options

Applicant: Provide the following information:

Make all checks payable to: Medico™ Insurance Company (do not make checks payable to the producer or leave payee line blank).

Method of Payment:

☐ Automatic Bank Withdrawal

☐ Direct Bill

Frequency of Payment:

☐ Monthly*

☐ Bi-Monthly

☐ Quarterly

☐ Semi-Annually

☐ Annually

*Monthly is not a payment option for Direct Bill.

Amount Received

Renewal

with Application \$ _____ Premium \$ _____

Requested Effective Date of Policy (optional) _____

(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Co-Applicant: Provide the following information:

Make all checks payable to: Medico™ Insurance Company (do not make checks payable to the producer or leave payee line blank).

Method of Payment:

☐ Automatic Bank Withdrawal

☐ Direct Bill

Frequency of Payment:

☐ Monthly*

☐ Bi-Monthly

☐ Quarterly

☐ Semi-Annually

☐ Annually

*Monthly is not a payment option for Direct Bill.

Amount Received

Renewal

with Application \$ _____ Premium \$ _____

Requested Effective Date of Policy (optional) _____

(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Part F: Application Agreement

I hereby apply to Medico™ Insurance Company for a **Dental, Vision and Hearing Insurance Policy** to be issued solely and entirely in reliance on my written answers to the above questions. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. These statements will become a part of any policy to which this form is attached. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid by the time the policy is delivered, and unless the policy is delivered and accepted by me.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, the Medical Information Bureau or other organization, institution or person, or prescription/pharmaceutical database that has any record or knowledge of me or my health, to give to Medico™ Insurance Company any such information. I understand that a photocopy of this authorization shall be as valid as the original and that this authorization shall remain valid for 24 months unless revoked by me in writing to the Home Office of Medico™ Insurance Company.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

Check one of the following if you are eligible for Medicare and "A Guide to Health Insurance for People With Medicare" is required in your state:

Applicant Co-Applicant

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at gomedico.com/products . |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. I have received a hard copy of the Medicare Buyers Guide. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. I am not eligible for Medicare. |

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or if the misrepresentation was material to our acceptance of the risk, rescind your policy.

I acknowledge that in states where it is required, the producer met with me on this date, made the necessary inquiries concerning my insurance needs and proposed a program of insurance which is suitable for my needs. I am applying for this Dental, Vision and Hearing insurance.

Applicant's Signature _____ Date _____

Co-Applicant's Signature _____ Dated at _____
City State

Producer's Name _____
(Please print)

Producer's Signature _____ Date _____

FLESCH READABILITY CERTIFICATION

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

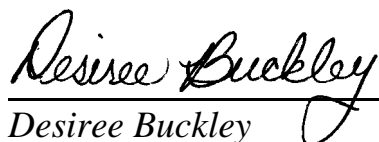
Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

MEDICO INSURANCE COMPANY



Desiree Buckley

Vice President, Director of Compliance



MEDICO™ GROUP

Medico™ Insurance Company • Medico™ Life Insurance Company

November 7, 2008

MEDICO INSURANCE COMPANY
NAIC #31119

Commissioner Julie Benafield Bowman
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Individual Dental, Vision and Hearing Policy
MI-DVA18

Enclosed (new) Material for Review:

Elimination Rider - RE487DV

Enclosed Previously Reviewed Material:

MIHAA18(AR)

Enclosed please find a copy of Elimination Rider RE487DV. It will be used in conjunction with our previously approved Dental, Vision and Hearing Product, approved on April 21, 2008.

If a new applicant answers "yes" to Part B, questions 3(b) and/or (c) of the application (attached for reference purposes), they will receive this rider when their policy is issued. They will need to sign the rider, send one copy to our office and keep a copy for their records showing their acceptance of this exclusion during the first Policy Year.

This exclusion will allow us to issue this policy, which also provides dental and vision benefits. Meanwhile, this exclusion will reduce the anti-selection risk for those who attempt to purchase this policy to pay for a hearing aid and then lapse. Our product was not priced to pay for hearing aids during the first Policy Year.

I thank you in advance for your prompt review and approval of this submission. If you have any questions, please feel free to contact me.

Sincerely,

Karl Hug, HIA
Compliance Analyst
1-800-695-5976 Ext. 251
Fax (402) 391-4858
khug@gomedico.com

Protecting Your Future Today®